I. EXECUTIVE SUMMARY

The Health Benefit Plan Member's Bill of Rights law passed by the Council of the District of Columbia in 1998, as codified at D.C. Official Code § 44-301 *et seq.*, established a procedure for members to appeal adverse decisions by insurers, which deny, limit, or terminate covered medical services on the grounds of being not medically necessary.

The law requires: 1) health insurers to send written notice of the adverse decision to the member or the member's representative within five (5) business days of the denial; 2) the written notice to inform the member of internal grievance and external appeal processes; and 3) the member to file an external appeal with the Director of the Department of Health (DOH) or his designee, the Grievance and Appeal Coordinator, within thirty (30) business days after receipt of an adverse decision letter from the insurer.

Furthermore, the law requires: 1) the DOH to contract with the Independent Review Organization (IRO) to review appeals and 2) all insurers to report their number of adverse decisions to the DOH.

The law requires that an annual report be compiled that summarizes the data reported to the DOH by health insurers.

II. DISTRICT OF COLUMBIA'S GRIEVANCE AND APPEALS LAW

The review of adverse decisions is divided into two parts: a) internal review, which is conducted by the insurer; and b) external review, which is conducted by DOH.

A. Internal Review: Insurer's Internal Grievance Process

If an insurer denies services based upon the lack of medical necessity, the insurer must provide its members with a written adverse decision within five (5) business days. The written adverse decision must include the following:

- A clearly stated decision;
- A detailed, comprehensible contractual or medical reason explaining the insurer's decision;
- An explanation of the insurer's internal grievance process;
- Notice that DOH can facilitate an external appeals process if members are dissatisfied with the insurer's grievance decision;
- Notice that members have thirty (30) days from the date of the final adverse decision to file an appeal with the DOH;
- The address, telephone number, and facsimile number of the DOH designee.

1. Requirements of Insurers

D.C. Official Code § 44-301.10 *et seq.* requires insurers to submit an annual report, which chronicles all activity during the preceding year. The report must include the following:

- The name and location of the reporting insurer;
- The reporting period in question;
- The names of the individuals responsible for the operation of the insurer's grievance system;
- The total number of grievances received by the health insurer categorized by cause, insurance status, and disposition;
- The total number of grievances for expedited review categorized by cause, length of time for resolution, and disposition; and
- The total number of appeals for external review categorized by cause, length of time for resolution, and disposition.

B. External Review: Appeals Process of DOH

If members are dissatisfied with the insurer's grievance decision related to the determination of the medical necessity of a claim, members may file an appeal at the following address: ***District of Columbia Department of Health, Office of the General Counsel, Attn: Grievance and Appeals Coordinator, 825 North Capitol Street, N.E., 4th Floor, Washington, D.C., 20002***.

The Grievance and Appeal Coordinator reviews cases to determine whether there should be a referral to an Independent Review Organization (IRO) for medical review. IROs are separate entities under contract with DOH that review appeal cases. They are comprised of certified medical professionals and physicians who specialize in the issue under review. IROs assess appeal cases on the basis of medical records, practice guidelines, and applicable clinical protocols. There is no cost to the members for an independent review. Under normal circumstances, an IRO must render a decision within thirty(30) days after receiving relevant documents. However, IROs must review emergency appeals within seventy-two (72) hours.

1. Additional Appeal Filing Locations

If members have concerns regarding the quality of services rendered by a physician, they may file a complaint at the following address: ***District of Columbia Department of Health, Health Regulatory Administration, 825 North Capitol Street, N. E., 2nd Floor, Washington, D.C., 20002. The telephone number is (202) 442-5888.***

Also, if members have concerns about services covered in their insurer's contract, they may file a complaint at the following address: ***Commissioner of the Department of Insurance Securities and Banking, 801 First Street, N. E., 7th Floor, Washington, D.C., 20002. The telephone number is (202) 727-8000.***

III. CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS

Upon the certification of an IRO, the DOH Director enforces standards to ensure independent review organizations do the following: (1) review appeals in strict confidentiality; (2) use qualified professionals and medical reviewers; and (3) demonstrate an ability to render decisions in an equitable and timely manner.

An IRO may not be a subsidiary or in any way owned or controlled by a health insurer, or trade association of health care providers. Also, the IRO should not have any material, professional, familial, or financial conflict of interest with the following: (1) insurer; (2) any officer, director, or management employee of the insurer; (3) the physician, physician's medical group, independent practice associates, or the provider proposing the service or treatment; (4) the institution at which the service or treatment should be provided; or (5) the development or manufacture of the principal drug, device, procedure, or other therapy proposed for the member whose treatment is under review.

The Director of DOH has the discretion to deny an appeal assignment to a particular IRO if it yields a conflict or appearance of impropriety. Also, neither the IRO nor an individual working for an external review panel can be held liable for any recommendation presented by the independent review organization, except in cases of gross negligence, recklessness, or intentional misconduct.

IV. STATISTICAL DATA BASED ON APPEALS FILED WITH DOH

During the October 1, 2003 to September 30, 2004 reporting period, DOH's Grievance and Appeal Coordinator received a total of seventy-seven (77) external appeals. The IROs reviewed twenty-three (23) appeals asserting a denial of coverage based upon the lack of medical necessity. One (1) appeal was withdrawn because it was filed before the health insurer had reached its final decision in the internal grievance process. Ten (10) appeals were rejected because they did not involve medically necessary services. Nineteen (19) appeals were referred to the Department of Insurance Securities and Banking because they involved coverage or contract interpretation issues. Fourteen (14) appeals were administratively dismissed. Appeals are usually administratively dismissed due to lack of sufficient information, i.e. a letter requesting a member to sign the authorization for the release of medical records or additional information was not responded to within a specified time frame. Four (4) appeals were referred to another agency for resolution. Finally, the health insurer reversed two (2) of their adverse decisions due to the receipt of additional information, which the member did not provide the health insurer during the internal grievance process. Four (4) appeals were returned to the member to exhaust their internal appeals process with the insurer.

V. CONSUMER AWARENESS

The success of the program depends heavily on consumer awareness. In FY 2004, there were approximately fourteen hundred (1,400) requests for assistance from consumers and providers. Requests for assistance were in the form of correspondence, telephone and facsimile inquiries requesting information about the program, assistance with completing necessary forms, and explanations of both the insurer's internal grievance process and DOH's external appeals process.

The law requires all insurers issuing adverse decision letters to notify the member of the internal and external appeal processes. Despite the explanations, many consumers continuously express confusion and frustration about exhausting the internal grievance and external appeal processes. Consumers indicate distrust in receiving fair grievance and appeal decisions and cite that their health benefit plan is unresponsive at times. In fact, such feelings have led several consumers to forgo the processes

Lastly, in an attempt to ensure that members were aware of their appeal rights, DOH utilized various consumer awareness efforts. DOH has done the following: 1) appeared at community meetings, legal seminars, and health programs sponsored by non-profit corporations; 2) developed an informational brochure and distributed it to various health care providers; and 3) created a web site that details information about the Program, including (a) an appeal form and (b) an authorization for the release of medical records form. It has also been advertised in local newspapers, and on television and radio.

VI. CONCLUSION

Overall, in FY 2004, the Health Benefits Plan Members' Bill of Rights program was successful. The program processed one hundred percent (100%) of the appeals received and provided a greater degree of assistance to members than in previous years, while ensuring that each member received a full and fair review of their appeal.

Appeals accepted by the DOH in 2004 can be separated into six (6) categories: (1) Inpatient Hospital Stays (4 appeals); (2) Emergency Room Services (1 appeal); (3) Mental Health Services (11 appeals); (4) Physician Services (3 appeals); (5) Speech Therapy (3 appeals); and (6) Chiropractic Services (1 appeal).

The range of services determined to be covered by the DOH after being denied by the insurer were:

- Inpatient Hospital Stays
- Mental Health Services
- Speech Therapy based on Medical Necessity

The health insurers also reported the number of internal grievances, which they overturned (See Tab B). The combined data shows that in 2004, forty-eight percent (48%) of the internal adverse decisions were upheld, fifty percent (50%) were reversed with two percent (2%) being modified.

Based on the reports submitted, it is clear that the law has had a positive effect on the ability of consumers to obtain medically necessary services. The Health Insurer's Annual Grievance Reports are set forth in the attached Appendix.

VII. RECOMMENDATIONS

While the program is successful there are measures that should be enacted to ensure that the health consumer's rights are fully protected. Therefore, in accordance with D.C. Official Code Sec. 44-301.10 (d), the following recommendations are made:

(1) Determinations of the Independent Review Organizations should be binding on both parties or at a minimum the health benefit plan. Under current law the determinations are not binding. Therefore, if the health insurer decides not to abide by the determination of the independent review organization, the member would then have the expenses and time associated with seeking a remedy through the courts.

(2) The DOH should have regulatory authority under the law. The DOH should have the authority to levy fines when a health insurer fails to follow the law, regulations or its internal grievance procedures.

(3) The definition section of the law should be reviewed to ensure that they are consistent with current practice definitions. (Example: "Health Insurer", use HIPPA's definition to ensure no impact on self-insured plans under ERISA).

(4) Legislation to make Gastric By-Pass Surgery a benefit available to citizens of the District of Columbia, as it is for citizens of Maryland and Virginia.

SUMMARY OF APPEALS REVIEWED BY INDEPENDENT REVIEW ORGANIZATIONS
LISTED BY INSURER
OCTOBER 2003 - SEPTEMBER 2004

Insurer	Total	Insurer Upheld by IRO	Insurer Reversed by IRO	Insurer Modified by IRO
AETNA	1	1	0	0
CAREFIRST	16	10	5	1
MAMSI	3	1	2	0
MUTUAL OF OMAHA	1	0	1	0
UNICARE	2	0	0	2
TOTAL	**23**	**12**	**8**	**3**

APPEALS BY JURISDICTION
OCTOBER 2003 - SEPTEMBER 2004

DC	MD	VA	OTHER*	TOTAL
20	32	14	11	**77**

*** CA(3), CO(1), FL(1), HI(1), LA(1), NJ(2), OR(1), TX(1)**

INDEPENDENT REVIEW BY JURISDICTION
OCTOBER 2003 – SEPTEMBER 2004

DC	MD	VA	OTHER++	TOTAL
5	12	4	2	**23**

++ CA(1), OR(1)

SUMMARY OF APPEALS REFERRED BY DOH
(BY INSURER)
OCTOBER 2003 - SEPTEMBER 2004

INSURER	TOTAL	REFERRED TO
CareFirst	10	Department of Insurance, Securities and Banking
MAMSI	7	Department of Insurance, Securities and Banking
Kaiser Permanente	2	Department of Insurance, Securities and Banking
CareFirst	1	Department of Labor
Kaiser Permanente	1	Department of Labor
Core Source	1	Department of Labor
CareFirst	1	Maryland Insurance Administration
TOTAL	**23**	

TOTAL APPEALS FILED
OCTOBER 2003 - SEPTEMBER 2004

APPEALS FILED	**77**
Referred to Department of Insurance, Securities and Banking	19
Referred to Other*	4

DECISIONS	
Insurer Upheld by Independent Review Organization	12
Insurer Reversed by Independent Review Organization	8
Insurer Modified by Independent Organization	3
Insurer Reversed Itself After Appeal Filed	2
Referred back to Member to Exhaust Internal Appeal Process	4
Appeal Withdrawn	1
Appeal Rejected	10
Appeal Administratively Dismissed	14

***** Department of Labor (ERISA) - 3
Maryland Insurance Administration - 1

SUMMARY OF APPEALS REFERRED TO INDEPENDENT REVIEW ORGANIZATIONS (LISTED BY SERVICE TYPE) 2004

Type of Service	Total	Insurer Upheld (DOH)	Insurer Reversed (DOH)	Appeal Rejected (DOH)
Inpatient Hospital Services	4	2	2	0
Emergency Room Services	1	0	1	0
Mental Health Services	11	6	5	0
Physicians' Services	3	2	1	0
Laboratory and Radiology Services	0	0	0	0
Pharmacy Services	0	0	0	0
PT, OT, and ST Services / Inpatient Rehab Services	3	1	2	0
Skilled Nursing Services	0	0	0	0
Durable Med. Equipment Services	0	0	0	0
Podiatry Services	0	0	0	0
Dental Services	0	0	0	0
Optometry Services	0	0	0	0
Chiropractic Services	1	0	1	0
Home Health Services	0	0	0	0
Other	0	0	0	0
Total	**23**	**11**	**12**	**0**

SUMMARY GRIEVANCE DATA SUBMITTED BY INSURER*
(2004)

INSURER'S NAME	GRIEVANCES REPORTED BY INSURER	GRIEVANCE DECISIONS UPHELD	GRIEVANCE DECISIONS REVERSED	GRIEVANCE DECISIONS MODIFIED
Aetna Health Care, Inc.	0	0	0	0
Allianz Life Insurance Co. of North America	0	0	0	0
American Specialty Health	0	0	0	0
Ameri-Group District of Columbia	3	1(33%)	2(67%)	0
Ameritas Life Insurance Co.	1	1(100%)	0	0
Capitol Community Health Plan	0	0	0	0
CareFirst Group Hospital & Medical Services	242	130(54%)	105(43%)	7(3%)
CareFirst BlueChoice	0	0	0	0
CIGNA Healthcare Mid Atlantic Inc.	8	3(37%)	5(63%)	0
Clarendon National Insurance Co.	0	0	0	0
Connecticut General Life Insurance Co.	51	26(51%)	24(47%)	1(2%)
Fidelity Security Life Insurance Co.	0	0	0	0
Fortis Benefits Insurance Co.	3	1(33%)	2(67%)	0
Fortis Insurance Co.	9	4(44%)	5(56%)	0

GE Group Life Assurance Co.	0	0	0	0
Golden Rule Insurance Co.	0	0	0	0
Guardian Life Insurance Co. of America	18	8(44%)	10(56%)	0
John Alden Life Insurance Co.	19	11(58%)	8(42%)	0
Kaiser Permanente	177	85(48%)	92(52%)	0
MAMSI Life and Health	223	105(45%)	114(49%)	4(6%)
MD-Individual Practice Assoc. Inc.	36	15(42%)	20(56%)	1 (2%)
Mutual of Omaha	1	0	1(100%)	0
Optimum Choice	523	240(46%)	271(52%)	12(2%)
Pacific Life & Annuity Co.	3	2(67%)	1(33%)	0
Principal Financial Grp.	2	2(100%)	0	0
Reliance Standard Life Insurance Co.	0	0	0	0
Trustmark Insurance Co.	0	0	0	0
Unicare	9	6(67%)	3(33%)	0
United Health Care of the Mid-Atlantic Inc.	25	8(32%)	14(56%)	3(12%)
United Wisconsin Life Insurance Co.	3	0	3(100%)	0
TOTAL	**1356**	**648(48%)**	**680(50%)**	**28(2%)**